Employment Options, LLC
91 Willenbrock Road, Unit A-3
Oxford, CT 06478
Phone: 203-267-3810 Fax: 203-267-3813

November 18, 2009

To Whom It May Concern:

Enclosed please find the Letter of Intent Form along with the Project Description.

Thank you.

Sincerely,

MZSmith

Michele Zurko-Smith
CEO

State of Connecticut
Office of Health Care Access
Letter of Intent Form
Form 2030

All Applicants involved with the proposal must be listed for identification purposes. A proposal's Letter of Intent (LOI) form must be submitted prior to a Certificate of Need application submission to OHCA by the Applicant(s), pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please complete and submit Form 2030 to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If this proposal has more than two Applicants, please attach a separate sheet, supplying the same information for each additional Applicant in the format presented in the following table.

	Applicant One	Applicant Two
Full legal name	Michele Zurko-Smith	
Doing Business As	Litchfield Hills Retreat L.L.C.	
Name of Parent Corporation	Employment options L.L.C.	
Applicant's Mailing Address, if Post Office (PO) Box, include a street mailing address for Certified Mail (Zip Code Required)	12 Trefoil Rd Oxford, CT 06478	
Identify Applicant Status: P for Profit or NP for Nonprofit	P	
Does the Applicant have Tax Exempt Status?	Yes (No)	Yes No
Contact Person, including Title/Position: This Individual will be the Applicant Designee to receive all correspondence in this matter.	Michele Zurko-Smith CEO member L.L.C	
Contact Person's Mailing Address, if PO Box, include a street mailing address for Certified Mail (Zip Code Required)	12 Trefoil Rd Oxford, CT 06478	
Contact Person Telephone Number	203-206-8212 203-267-3818	
Contact Person Fax Number	203-267-3813	
Contact Person e-mail Address	MLZURKO@AOL.com	

SECTION II. GENERAL APPLICATION INFORMATION

a. Project Title: Litchfield Hills Retreat L.L.C

b. Project Proposal: Substance Abuse Services + Behavioral Health

c. Type of Project/Proposal, please check all that apply:

Inpatient Service(s):

- ☐ Medical/Surgical ☐ Cardiac ☐ Pediatric ☐ Maternity
- ☐ Trauma Center ☐ Transplantation Programs
- ☐ Rehabilitation *(specify type)* _____
- ☑ Behavioral Health (Psychiatric and/or Substance Abuse Services)
- ☐ Other Inpatient *(specify)* _____

Outpatient Service(s):

- ☐ Ambulatory Surgery Center ☐ Primary Care ☐ Oncology
- ☐ New Hospital Satellite Facility ☐ Emergency ☐ Urgent Care
- ☐ Rehabilitation *(specify type)* _____ ☐ Central Services Facility
- ☐ Behavioral Health (Psychiatric and/or Substance Abuse Services)
- ☐ Other Outpatient *(specify)* _____

Imaging:

- ☐ MRI ☐ CT Scanner ☐ PET Scanner
- ☐ CT Simulator ☐ PET/CT Scanner ☐ Linear Accelerator
- ☐ Cineangiography Equipment ☐ New Technology: _____

Non-Clinical:

- ☐ Facility Development ☐ Non-Medical Equipment ☐ Renovations
- ☐ Change in Ownership or Control ☐ Land and/or Building Acquisitions
- ☐ Organizational Structure (Mergers, Acquisitions, & Affiliations)
- ☐ Other Non-Clinical: _____

d. Does the proposal include a Change in Facility (F), Service (S)/Function (Fnc) pursuant to Section 19a-638, C.G.S.?

☑ Yes ☐ No

If you checked "Yes" above, please check the appropriate box below:

- ☑ New (F, S, Fnc) ☐ Additional (F, S, Fnc) ☐ Replacement
- ☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Termination of Service
- ☐ Reduction ☐ Change in Ownership/Control

e. Will the Capital Expenditure/Cost of the proposal exceed $3,000,000, pursuant to Section 19a-639, C.G.S.?

☐ Yes ☑ No

If you checked "Yes" above, please check the boxes below, as appropriate:

☐ New equipment acquisition and operation

☐ Replacement equipment with disposal of existing equipment

☐ Major medical equipment

☐ Change in ownership or control

f. Location of proposal, identifying Street Address, Town and Zip Code:

64 Double Hill Rd, Bethlehem, CT 06751

g. List each town this project is intended to serve:

State wide

h. Estimated starting date for the project: Feb, 2010

i. If the proposal includes change in the number of beds provide the following information:

Type	Existing Staffed	Existing Licensed	Proposed Increase or (Decrease)	Proposed Total Licensed

SECTION III. ESTIMATED CAPITAL EXPENDITURE/COST INFORMATION

a. Estimated Total Project Expenditure/Cost: $ 2,500,000.

b. Please provide the following tentative capital expenditure/costs related to the proposal:

Major Medical Equipment Purchases*	
Medical Equipment Purchases*	
Non-Medical Equipment Purchases*	
Land/Building Purchases	
Construction/Renovation	2,000,000 –
Other (Non-Construction) Specify: Furinshings + recreational equip.	500,000
Total Capital Expenditure	
Major Medical Equipment – Fair Market Value of Leases Medical	
Equipment – Fair Market Value of Leases	
Non-Medical Equipment – Fair Market Value of Leases*	
Fair Market Value of Space – Capital Leases Only	
Total Capital Cost	
Total Project Cost	
Capitalized Financing Costs (Informational Purpose Only)	

* Provide an itemized list of all medical and non-medical equipment to be purchased and leased.

c. If the proposal has a total capital expenditure/cost exceeding $20,000,000 or if the proposal is for major medical equipment exceeding $3,000,000, you may request a Waiver of Public Hearing pursuant to Section 19a-643-45 of OHCA's Regulations? Please check your preference.

☐ Yes ☑ No

1. If you checked "Yes" above: please check the appropriate box below indicating the basis of the projects eligibility for a waiver of hearing

   ☐ Energy Conservation ☐ Health, Fire, Building and Life Safety Code

   ☐ Non Substantive

2. Provide supporting documentation from elected town officials (i.e. letter from Mayor's Office).

d. Major Medical and/or Imaging Equipment Acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

Note: Provide a copy of the vendor contract or quotation for each major medical/imaging equipment.

e. Type of financing or funding source (more than one can be checked):

- ☑ Applicant's Equity
- ☐ Capital Lease
- ☑ Conventional Loan
- ☐ Charitable Contributions
- ☐ Operating Lease
- ☐ CHEFA Financing
- ☐ Funded Depreciation
- ☐ Grant Funding
- ☐ Other *(specify)* _____

SECTION IV. PROJECT DESCRIPTION

In paragraph format, please provide a description of the proposed project, highlighting each of its important aspects, on at least one, but not more than two separate 8.5" X 11" sheets of paper. At a minimum each of the following items need to be addressed, if applicable.

1. List the types of services are currently being provided. If applicable, provide a copy of each Department of Public Health (DPH) license held by the Applicant.

2. List the types of services being proposed and what DPH licensure categories will be sought, if applicable.

3. Identify the current population served and the target population to be served.

4. Identify any unmet need and describe how this project will fulfill that need.

5. Are there any similar existing service providers in the proposed geographic area?

6. Describe the anticipated effect of this proposal on the health care delivery system in the State of Connecticut.

7. Who will be responsible for providing the service?

8. Who are the current payers of this service and identify any anticipated payer changes when the proposed project becomes operational?

AFFIDAVIT

To be completed by each Applicant

Applicant: Michele Zurko-Smith

Project Title: Litchfield Hills Retreat L.L.C
High End Treatment Center for substance abuse

I, Michele Zurko-Smith (Name), CEO/member L.L.C. (Position – CEO or CFO)
of Employment options L.L.C being duly sworn, depose and state that the information provided in this CON Letter of Intent (Form 2030) is true and accurate to the best of my knowledge, and that Litchfield Hills (Facility Name) complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature 11/18/09
Date

Subscribed and sworn to before me on 11/18/2009

Amy H. Cravetz
Notary Public/Commissioner of Superior Court

AMY H. CRAVETZ
NOTARY PUBLIC
My Comm. Expires Dec. 31, 2009

My commission expires:

RECEIVED
2009 NOV 20 A 11:31
CONNECTICUT OFFICE OF HEALTH CARE ACCESS

11/10/09

Project Description

Employment Options L.L.C. is a private social service agency that was established in 1994. Michele Zurko-Smith is the CEO and a member of the L.L.C. of this company which currently employs one hundred thirty eight people. Employment Options has a vocational contract with the Bureau of rehabilitation services and is also the largest provider for the Acquired Brain Injury waver in the state of Connecticut, offering residential supports, independent living skills training, as well as vocational services. Employment Options services twenty two individual private service plans through the Department of Developmental Services, supporting people in the community residentially and vocationally. Employment Options also works with a number of different school districts through out the years, assessing students and working with them towards reaching their life goals.

A large number of people we serve have or have had, substance abuse issues.

Employment Options would like to expand into substance abuse residential treatment for individuals over the age of eighteen. We will accept a person into residential treatment after they are medically cleared by a physician (we will not be offering Detox or any other medical service). We will have a License drug and alcohol counselor on staff and will offer treatment plans that incorporate nationally accepted addiction treatment models. We anticipate the length of stay to be a minimum of twenty eight days.

Employment Options purposes a new free standing Facility which will be located in Bethlehem, CT. We would like to have a total of twenty eight beds. This facility will be located on sixty two, very private acres, offering private and semi private rooms. This facility will be private pay and be marketed to a higher level professional and or their family member. This facility is intended to serve people whose public visibility, wealth, fame or social position would make it impossible for them to begin recovery in a traditional residential treatment center that currently exists in Connecticut.

Currently there is not a Connecticut based facility that can offer this type of service. Professional residents (Physicians, Attorneys, Politicians, Actors, etc.) are greatly under served in our state. We have a number of residents needing substance abuse residential treatment, that fit the criteria and must leave the state to find a substance abuse treatment center that is suitable for their recovery.

This will be a confidential treatment center that is offered in Connecticut to serve Connecticut (and out of state) professionals. People that live in our state and need this type of service, could benefit from a closer proximity to family and after care supports. Keeping the professional in his home state *may* also allow him to continue working during residential treatment.

Employment Options has created a separate company. The name for this residential treatment center will be Litchfield Hills Retreat L.L.C. The property in Bethlehem, is currently owned by Litchfield Hills Retreat L.L.C. and there is an eight bed , 7,500 sq ft. home on the property. An additional building would be built for the additional beds, office and program space. Money from the CEO of the company, Michele Zurko-Smith, as well as a traditional construction loan would finance this project.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 7, 2009 Facsimile Only

Michele Zurko-Smith
CEO Member LLC
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
12 Trefoil Road
Oxford, CT 06478

Re: Letter of Intent; Docket Number: 09-31500
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Establish a Free Standing Substance Abuse Facility in Bethlehem
Notice of Letter of Intent

Dear Ms. Zurko-Smith:

On November 20, 2009, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC ("Applicant") to establish a free standing substance abuse facility in Bethlehem, with a total capital expenditure of $2,5000,000.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Republican American* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Kimberly R. Martone
Director of Operations

KRM:lmg

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

December 7, 2009 Requisition # 029695

Republican American
389 Meadow Street
Box 2090
Waterbury, CT 06722-2090

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than **Friday, December 11, 2009.**

Please provide the following within 30 days of publication:

- Proof of publication (copy of legal ad acceptable) showing published date along with the invoice.

If there are any questions regarding this legal notice, please contact Steven Lazarus at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Kimberly R. Martone
Director of Operations

Attachment

KRM:SWL:lmg

c: Danielle Pare, DPH

Republican American
Docket Number: 09-31500

Letter of Intent
December 7, 2009

PLEASE INSERT THE FOLLOWING:

Statute Reference:	19a-638
Applicant:	Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Town:	Bethlehem
Docket Number:	09-31500-LOI
Proposal:	Establish a Free Standing Substance Abuse Facility
Capital Expenditure:	$2,5000,000

The Applicant may file its Certificate of Need application between January 19, 2010 and March 20, 2010. Interested persons are invited to submit written comments to Cristine A. Vogel, Deputy Commissioner Office of Health Care Access, Division of Department of Public Health, 410 Capitol Avenue, MS13HCA P.O. Box 340308 Hartford, CT 06134-0308.

The Letter of Intent is available at OHCA or on OHCA's website at www.ct.gov/OHCA. A copy of the Letter of Intent or a copy of Certificate of Need Application, when filed, may be obtained from OHCA at the standard charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicants.

Greer, Leslie

From: ads [ads@graystoneadv.com]
Sent: Monday, December 07, 2009 2:56 PM
To: Greer, Leslie
Subject: Re: Requisition 029695
Importance: High

Good day!

Thanks so much for your ad submission.
We will be in touch shortly and look forward to serving you.

If you have any questions or concerns, please don't hesitate to contact us at the number below.

We sincerely appreciate your business.

Thank you,
Graystone Group Advertising

2710 North Avenue
Bridgeport, CT 06604
Phone: 800-544-0005
Fax: 203-549-0061
E-mail: ads@graystoneadv.com
http://www.graystoneadv.com/

On 12/7/09 2:24 PM, "Greer, Leslie" <Leslie.Greer@ct.gov> wrote:

> To Whom It May Concern,
> Please run the attached public notice s in the attached mentioned newspapers. I have attached a hearing notice that has to run in tomorrow s newspaper. Please let me know if this is a problem, call with any questions.
>
> Thank you,
>
> Leslie M. Greer
> Office of Health Care Access
> A Division of Department of Public Health
> tate of Connecticut
> 410 Capitol Avenue, MS 13HCA
> Hartford, CT 06134
> Phone: 860 418-7001
> Fax: 860 418 -7053
> Website:www.ct.gov/ohca <http://www.ct.gov/ohca>
> 1 Please consider the environment before printing this message

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	0948
RECIPIENT ADDRESS	912032673813
DESTINATION ID	
ST. TIME	12/07 17:23
TIME USE	01'01
PAGES SENT	4
RESULT	OK

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF HEALTH CARE ACCESS

FAX SHEET

TO: MICHELE ZURKO-SMITH

FAX: (203) 267-3813

AGENCY: EMPLOYMENT OPTIONS D/B/A LITCHFIELD HILLS RETREAT, LLC

FROM: STEVEN LAZARUS

DATE: 12/7/09 **TIME:**

NUMBER OF PAGES: 4
(including transmittal sheet

Comments: Docket 09-31500-LOI

PLEASE PHONE IF THERE ARE ANY TRANSMISSION PROBLEMS.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

December 8, 2009

via fax and email only

Michele Zurko-Smith
Lithcfield Hills Retreat, LLC
12 Trefoil Road
Oxford, CT 06478

RE: Certificate of Need Application Forms, Docket Number 09-31500-LOI
Employment Options, LLC d/b/a Litchfield Hills Retreat, LLC
Establishment of a Free Standing Outpatient Adult Substance Abuse and Behavioral Health Services Facility in Bethlehem, Connecticut

Dear Ms. Zurko-Smith:

Enclosed are the application forms for Employment Options, LLC d/b/a Litchfield Hills, LLC's Certificate of Need ("CON") proposal for the establishment of a free standing outpatient adult substance abuse and behavioral health services facility in Bethlehem, Connecticut with an associated capital expenditure of $2,500,000. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes, the CON application may be filed between January 19, 2010, and March 20, 2010.

When submitting your CON application and any subsequent application information to this agency, you are obligated to observe the following procedural requirements. **Failure to observe these requirements will require follow-up work on your part to correct the filing.**

- Number and date each page, including cover letter and all attachments. Information filed after the initial CON application submission (i.e. completeness response letter, prefile testimony, late file submissions and the like) must be numbered sequentially from the Applicant's document immediately preceding it. For example, if the application concludes with page 100, your completeness response letter would begin with page 101.

- Submit one (1) original and six (6) hard copies of each submission in 3-ring binders.
- Submit a scanned copy of each submission in its entirety, including all attachments on CD, preferably in Adobe (.pdf) format.
- Submit an electronic copy of the documents in MS Word format with financial attachments and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Steven W. Lazarus. Please contact him at (860) 418-7012 if you have questions.

Sincerely,

Kaila Riggott

Kaila Riggott
Planning Specialist

Enclosures

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than January 19, 2010, and may be submitted no later than March 20, 2010. The Analyst assigned to your application is Steven W. Lazarus and he may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 09-31500-CON

Applicant(s) Name: Employment Options, Inc d/b/a Litchfield Hills Retreat, LLC
Contact Person: Michele Zurko-Smith
Contact Title: Chief Executive Officer
Litchfield Hills Retreat, LLC
Contact Address: 12 Trefoil Road
Oxford, CT 06478

Project Location: Bethlehem

Project Name: Establishment of a Free Standing Outpatient Adult Substance Abuse and Behavioral Health Services Facility

Type proposal: Section 19a-638, C.G.S.

Est. Capital Expenditure: $2,500,000

1. Project Description and Need

a. Provide a narrative detailing the proposal.

b. Provide the following regarding the proposal's location:

i. The rationale for choosing the proposed service location;

ii. The service area towns and the basis for their selection;

iii. The population to be served, including specific evidence such as incidence, prevalence, or other demographic data that demonstrates need;

iv. How and where the proposed patient population is currently being served;

v. All existing providers (name, address, services provided) of the proposed service (similar and related services) in the towns listed above and in nearby towns; and

vi. The effect of the proposal on existing providers.

2. Projected Volume

a. Complete the following table for the first three fiscal years ("FY") of the proposed service.

Table 1: Projected Volume

	Projected Volume (First 3 Full Operational FYs)**			
	FY****	FY****	FY****	FY****
Service type***				
Total				

** If the first year of the proposal is only a partial year, provide the first partial year and then the first three full FYs. Add columns as necessary.
*** Identify each service/procedure type and add lines as necessary.
**** Fill in years. In a footnote, identify the period covered by the Applicant's FY (e.g. July 1-June 30, calendar year, etc.).

b. Provide a detailed explanation of all assumptions used in the derivation/ calculation of the projected volume.

c. Provide historical volumes for three full years and the current year to date for any of the Applicant's existing services that support the need to implement the proposed service.

d. Provide a copy of any articles, studies, or reports that support the statements made

in this application justifying need for the proposal, along with a brief explanation regarding the relevance of the selected articles.

3. Quality Measures

a. Submit a list of all key professional, administrative, clinical, and direct service personnel related to the proposal. Attach a copy of their Curriculum Vitae.

b. Explain how this proposal contributes to the quality of health care delivery in the region.

c. Describe the impact of the proposal on the interests of consumers of health care services and the payers of such services

d. Identify the Standard of Practice Guidelines that will be utilized in relation to the proposal. Attach copies of relevant sections and briefly describe how the Applicant proposes to meet each of the guidelines.

4. Organizational and Financial Information

a. Identify the Applicant's ownership type(s) (e.g. Corporation, PC, LLC, etc.).

b. Does the Applicant have non-profit status?
☐ Yes (Provide documentation) ☐ No

c. Provide a copy of the State of Connecticut, Department of Public Health license(s) currently held by the Applicant and indicate any additional licensure categories being sought in relation to the proposal.

d. Financial Statements

i. <u>If the Applicant is a Connecticut hospital:</u> Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the hospital has filed its most recently completed fiscal year audited financial statements, the hospital may reference that filing for this proposal.

ii. <u>If the Applicant is not a Connecticut hospital (other health care facilities):</u> Audited financial statements for the most recently completed fiscal year. If audited financial statements do not exist, in lieu of audited financial statements, provide other financial documentation (e.g. unaudited balance sheet, statement of operations, tax return, or other set of books.)

e. Submit a final version of all capital expenditures/costs as follows:

Table 2: Proposed Capital Expenditures/Costs

Medical Equipment Purchase	$
Imaging Equipment Purchase	
Non-Medical Equipment Purchase	
Land/Building Purchase *	
Construction/Renovation **	
Other Non-Construction (Specify)	
Total Capital Expenditure	$
Medical Equipment Lease (Fair Market Value) ***	$
Imaging Equipment Lease (Fair Market Value) ***	
Non-Medical Equipment Lease (Fair Market Value) ***	
Fair Market Value of Space ***	
Total Capital Cost	$
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	$

* If the proposal involves a land/building purchase, attach a real estate property appraisal including the amount; the useful life of the building; and a schedule of depreciation.
** If the proposal involves construction/renovations, attach a description of the proposed building work, including the gross sq. feet; existing and proposed floor plans; commencement date for the construction/ renovation; completion date of the construction/renovation; and commencement of operations date.
*** If the proposal involves a capital or operating equipment lease and/or purchase, attach a vendor quote or invoice; schedule of depreciation; useful life of the equipment; and anticipated residual value at the end of the lease or loan term.

f. List all funding or financing sources for the proposal, and the dollar amount of each. Provide applicable details such as interest rate; term; monthly payment; pledges received to date; letter of interest or approval from a lending institution.

5. Revenues, Expenses, and Patient Population Projections

a. Patient Population Mix

i. Provide the current and projected patient population mix (based on the number of patients, not on revenue) for the proposed program.

Table 3: Patient Population Mix

	Current** FY ***	Year 1 FY ***	Year 2 FY ***	Year 3 FY ***
Medicare*				
Medicaid*				
CHAMPUS & TriCare				
Total Government				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government				
Total Payer Mix				

* Includes managed care activity.
** New programs may leave the "current" column blank.

*** Fill in years. Ensure the period covered by this table corresponds to the period covered in the projections provided.

ii. Provide the basis for/assumptions used to project the patient population mix.

b. Financial Attachments I & II

i. Provide a summary of revenue, expense, and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **Complete Financial Attachment I.** (Note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.) The projections must include the first three full fiscal years of the project.

ii. Provide a three year projection of incremental revenue, expense, and volume statistics attributable to the proposal by payer. **Complete Financial Attachment II.** The projections must include the first three full fiscal years of the project.

iii. Provide the assumptions utilized in developing **both Financial Attachments I and II** (e.g., full-time equivalents, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

iv. Provide documentation or the basis to support the proposed rates for each of the FYs as reported in Financial Attachment II. Provide a copy of the rate schedule for the proposed service(s).

v. Provide the minimum number of units required to show an incremental gain from operations for each fiscal year.

vi. Explain any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

vii. Describe how this proposal is cost effective.

6. Other Review Criteria

a. Describe the proposal's relationship to the Applicant's long-range plans. Provide supporting documentation.

b. Specify whether any of the following apply to the proposal. If so, provide an explanation and supporting documentation.
   i. Voluntary efforts to improve productivity and contain costs;
   ii. Changes to the Applicant's teaching or research responsibilities; and/or
   iii. Special characteristics of the Applicant's patient or physician mix.

				Financial Attachment II						
Please provide **three** years of projections of incremental revenue, expense and volume statistics **attributable to the proposal** in the following reporting format:										
Type of Service Description										
Type of Unit Description:										
# of Months in Operation										
FY _____	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
FY Projected Incremental		Rate	Units	Gross	Allowances/	Charity	Bad	Net	Operating	Gain/(Loss)
Total Incremental Expenses:				Revenue	Deductions	Care	Debt	Revenue	Expenses	from Operations
				Col. 2 * Col. 3				Col.4 - Col.5	Col. 1 Total *	Col. 8 - Col. 9
Total Facility by								-Col.6 - Col.7	Col. 4 / Col. 4 Total	
Payer Category:										
Medicare				$0				$0	$0	$0
Medicaid		$0		$0				$0	$0	$0
CHAMPUS/TriCare		$0		$0				$0	$0	$0
Total Governmental			0	$0	$0	$0	$0	$0	$0	$0
Commericial Insurers		$0		$0				$0	$0	$0
Uninsured		$0		$0				$0	$0	$0
Total NonGovernment		$0	0	$0	$0	$0	$0	$0	$0	$0
Total All Payers		$0	0	$0	$0	$0	$0	$0	$0	$0

Financial Attachment I

Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and if applicable, volume statistics without, incremental to and with the proposal in the following reporting format:

Total Facility:	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY
	Actual	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
Description	Results	W/out Project	Incremental	With Project	W/out Project	Incremental	With Project	W/out Project	Incremental	With Project
Revenue from Operations				$0			$0			$0
Non-Operating Revenue				$0			$0			$0
Total Revenue:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Operating Expenses				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

*Volume Statistics:

*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Greer, Leslie

From: Lazarus, Steven
Sent: Tuesday, December 08, 2009 12:59 PM
To: mlzurko@aol.com
Cc: Greer, Leslie
Subject: CON Applicaiton for Docket No.: 09-31500-LOI
Attachments: 09-31500-Cover Letter.doc; 09-31500-CON Application.doc; 09-31500 FA1.xls; Financial Attachment II.xls; CON Affidavit-General.doc

Ms. Zurko-Smith,

Attached is a copy of the CON Application for Litchfield Hills Retreat, LLC. Please feel free to contact me if you have any further questions. A copy is also being faxed out to you shortly.

Have a great day,

Steven

Steven W. Lazarus
Associate Health Care Analyst
Office of Health Care Access
A Division of Department of Public Health
State of Connecticut
410 Capitol Avenue
Hartford, Connecticut 06134
Phone: (860) 418-7012 (Direct)
Fax: (860) 418-7053 (Main)